EXHIBIT B

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PI1-D

Personal Injury Claim Form

Electronically filed claims must be filed at the NYC Comptroller's Website. If your claim is not resolved within 1 year and 90 days from the date of occurrence you must start legal action to preserve your rights.

I am filing:
- ○ On behalf of myself.
- ○ On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:	
First Name:	
Relationship to the claimant:	

Claimant Information

*Last Name:	Terr
*First Name:	Chris
*Address:	MDC
Address 2:	
*City:	New York
*State:	NEW YORK
*Zip Code:	10013
*Country:	USA
Date of Birth:	*Format: MM/DD/YYYY*
Soc. Sec. #	
HICN: (Medicare #)	
Date of Death:	*Format: MM/DD/YYYY*
Phone:	
*Email Address:	mwalle1@gmail.com
*Retype Email Address:	mwalle1@gmail.com
Occupation:	

City Employee? ○ Yes ◉ No ○ NA

Gender ◉ Male ○ Female ○ Other

◉ Attorney is filing.

Attorney Information (If claimant is represented by attorney)

Firm or Last Name:	Law Office of Matthew B. Waller
Firm or First Name:	
Address:	20 Vesey Street
Address 2:	Suite 503
City:	New York
State:	NEW YORK
Zip Code:	10007
Tax ID:	
Phone #:	(212) 766-4404
*Email Address:	mwalle1@gmail.com
*Retype Email Address:	mwalle1@gmail.com

The time and place where the claim arose

*Date of Incident:	11/13/2019 *Format: MM/DD/YYYY*
Time of Incident:	*Format: HH:MM AM/PM*
*Location of Incident:	MDC, 9 north
Address:	
Address 2:	
City:	
*State:	NEW YORK
Borough:	MANHATTAN (NEW YORK)

**** Denotes required fields. A Claimant OR an Attorney Email Address is required.***

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***Manner in which claim arose:**	On November 13, 2019, the Claimant Chris Terr - B&C# 141-19-02613 was injured as a result of the negligence of the City of New York (CITY) and New York City Department of Correction (DOC) when he was caused to slip and fall and sustain serious injuries. On the aforementioned date and location as claimant was lawfully within the bathroom area claimant was caused to slip and fall as a result of wet ground. This Hazard/wet surface was left without warning and/or repair causing claimant to fall to the ground and sustain injuries. Such condition which constituted a hazardous and/or dangerous condition caused him to fall down. At no time did the Correction Staff put up signs making lawful users of the premises aware that the floor was wet/dangerous/defective or that a hazard was present and allowed the condition to remain for an unreasonable amount of time. As a result of the fall claimant sustained serious injuries including but not limited to injury to his head, neck, back, amongst other parts of his body. Notice both actual and constructive are claimed as either the City and/or the DOC created this condition and/or allowed this condition to exist for an unreasonable amount of time. A claim is made for negligence against the City and the DOC as the injuries occurred while the claimant was in their care, custody and control.

**** Denotes required field.***

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The items of damage or injuries claimed are (include dollar amounts):	For the serious injuries sustained by the claimant, including but not limited to his head, neck, back, amongst other parts of his body, a claim is made for one million ($1,000,000.00) dollars.

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Medical Information

1st Treatment Date:	*Format: MM/DD/YYYY*
Hospital/Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Date Treated in Emergency Room:	*Format: MM/DD/YYYY*

Was claimant taken to hospital by an ambulance? ◯ Yes ◯ No ◯ NA

Employment Information (If claiming lost wages)

Employer's Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	
Work Days Lost:	
Amount Earned Weekly:	

Treating Physician Information

Last Name:	
First Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	

Witness 1 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

Witness 2 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

Witness 3 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

Witness 4 Information

Last Name:			
First Name:			
Address			
Address 2:			
City:			
State:			
Zip Code:		Phone:	

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Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Non-City vehicle driver

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Insurance Information

Insurance Company Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	
Policy #:	
Phone #:	

Non-City vehicle information

Make, Model, Year of Vehicle:	
Plate #:	
VIN #:	

City vehicle information

Plate #:	
City Driver Last Name:	
City Driver First Name:	

Description of claimant:

◯ Driver ◯ Passenger
◯ Pedestrian ◯ Bicyclist
◯ Motorcyclist ◯ Other

Total Amount Claimed: $1,000,000.00 *Format: Do not include "$" or ",".*

*The **Total Amount Claimed** can only be entered once the following required fields are entered:*

Claimant Last Name
Claimant First Name
Claimant Address,City,State,Zip Code, and Country
Claimant Email or Attorney Email
Date of Incident
Location of Incident (including State)
Manner in which claim arose

I certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties and civil liabilities.